

### NCLEX Test Taking Strategy Questions

1. The nurse is providing post-operative care to a craniotomy client. Diabetes insipidus is suspected when the client's urine output suddenly increases significantly. Which action takes **highest** priority?

- 1. Monitoring urine output
- 2. Checking pulse
- 3. Checking blood pressure
- 4. Assessing level of consciousness

Rationale:

3. Correct: This is the best answer because we are “worried” this client is going into SHOCK. So.....you better be checking a BP. This is a time where checking the BP is appropriate. If we “assume the worst” I better check a blood pressure. It could have dropped out the bottom.

1. Incorrect: Continuing to monitor U/O is important but I need to find out if they are already shocky.

2. Incorrect: Checking the pulse is a good thing, but, not as important as checking the BP.

4. Incorrect: If my client is going into shock the highest priority is to assess the BP.

2. The client is being treated for fluid volume deficit. Which is an expected outcome of successful treatment?

- 1. Resolution of orthostatic hypotension
- 2. Maintenance of weight loss
- 3. Compliance with sodium restricted diet
- 4. Maintenance of serum Na above 148 mEq

Rationale:

1. Correct: When you are in a fluid volume deficit your blood pressure goes down when you stand up and it's called orthostatic hypotension. Successful treatment would resolve this.

2. Incorrect: When I have lost a lot of volume, my weight goes down, so if I am better, my weight should go up.

3. Incorrect: Who needs to adhere to dietary sodium restrictions? People who are in fluid volume excess.

4. Incorrect: If your serum sodium is above 148, hypernatremia is the same thing as dehydration, so this means that you are still sick.

3. The nurse in the intensive care unit is caring for a client receiving hemodynamic monitoring. When planning for a client's care, which nursing diagnoses associated with hemodynamic monitoring may be utilized by the nurse? **Select all that apply.**

- ☐ 1. Decreased cardiac output
- ☐ 2. Fluid volume deficit
- ☐ 3. Fluid volume excess
- ☐ 4. Ineffective tissue perfusion
- ☐ 5. Ineffective airway

Rationale:

1., 2., 3. & 4. Correct: Nursing diagnoses, associated with hemodynamic monitoring, that may be utilized by the nurse include decreased cardiac output, fluid volume deficit, fluid volume excess, and ineffective tissue perfusion. These nursing diagnoses relate to the pathophysiologic processes that alter one of the four hemodynamic mechanisms that support normal cardiovascular function: preload, afterload, heart rate, and contractility.

5. Incorrect: Ineffective Airway would not be associated with hemodynamic monitoring.

4. The nurse is caring for a client that has two IV access sites. One is a 20 gauge antecubital peripheral IV that was started yesterday for blood and has normal saline (NS) at keep vein open rate. The other is a double lumen central line catheter with one port for Total Parenteral Nutrition and the other is used for blood samples. Where is the **best** site for the nurse to administer 20 mEq of potassium chloride (KCL) in 100 mL of normal saline(NS) over 4 hours?

- ☐ 1. Central line port that is being used for lab draws
- ☐ 2. Same line with the Total Parenteral Nutrition
- ☐ 3. Large bore antecubital
- ☐ 4. Start another peripheral IV

Rationale:

1. Correct: Yes- K is very hard on the veins, give it through the central line.

2. Incorrect: No, never put anything through a line with Total Parental Nutrition.

3. Incorrect: Second best choice- but it will burn.

4. Incorrect: No, a central line is needed.

5. The nurse is caring for a client that has metabolic acidosis secondary to acute renal failure. What is the **initial** client response to this problem?

- 1. Respiratory rate increases to blow off acid.
- 2. Respiratory rate decreases to conserve acid and buffer the kidneys response.
- 3. Kidneys will excrete hydrogen and retain bicarb.
- 4. Sodium will shift to cells and buffer the hydrogens.

Rationale:

1. Correct: Yes, acute renal failure causes metabolic acidosis and the body is trying to breathe faster to blow off some acid. The respiratory response is fast.
2. Incorrect: No, the client's respiratory rate is fast, not slow.
3. Incorrect: This will happen, later. Did not we say about 48 hours? Not initial response.
4. Incorrect: Sodium is extracellular electrolyte, not an intracellular electrolyte.

6. The client presents to the emergency department with nausea, vomiting and anorexia for the last few days. An EKG on admission reveals an arrhythmia. Which electrolyte imbalance is suspected?

- 1. Hypercalcemia
- 2. Hypokalemia
- 3. Hypermagnesemia
- 4. Hyponatremia

Rationale:

2. Correct: The client has been vomiting so the electrolyte losses are potassium, hydrogen and chloride. The anorexia further complicates the condition because we get potassium from the foods we eat. The one electrolyte we worry about with arrhythmias is potassium.
1. Incorrect: What has calcium got to do with nausea and vomiting? Nothing
3. Incorrect: Magnesium is lost through the lower GI tract and Hypermagnesemia is not related to dysrhythmias.
4. Incorrect: The loss of sodium is related to diarrhea.

7. The nurse is caring for a client that is drowsy and has an elevated CO<sub>2</sub>. What are some common drugs that cause retained CO<sub>2</sub>? **Select all that apply**

- ☐ 1. Narcotics
- ☐ 2. Diuretics
- ☐ 3. Steroids
- ☐ 4. Antiemetics
- ☐ 5. Hypnotics

Rationale:

1., 4. & 5. Correct: Yes! – Narcotics sedate and decrease the respiratory rate. Some antiemetics like promethazine (Phenergan) are very sedating. Hypnotics can cause sedation to point of hypoventilation.

2. Incorrect: No – Diuretics do not affect breathing patterns.

3. Incorrect: No –Steroids do not affect breathing patterns

8. A client was admitted 24 hours ago with sepsis. Treatment included IV therapy of Lactated Ringers (LR) at 150 ml/hr, broad spectrum antibiotics, and steroid therapy. How will the nurse know that treatment has been successful? **Select all that apply.**

- ☐ 1. Blood pressure 96/68; HR- 98; RR- 20
- ☐ 2. Serum Glucose- 110
- ☐ 3. Hgb- 12; Hct- 38
- ☐ 4. pH- 7.30; pCO<sub>2</sub>- 48; HCO<sub>3</sub>- 24
- ☐ 5. Urinary output at 25 ml/hr
- ☐ 6. Awake, alert to person, place and time

Rationale:

1., 2., 3. & 6. Correct: The systolic BP should be greater than 90. The other lab work is normal as well.

4. Incorrect: The client is still in respiratory acidosis, so is not better.

5. Incorrect: Urinary output should be at least 30 ml/hr.

9. The daytime charge nurse identifies that a client was treated for what condition during the night after reading the following chart entries?

*Progress Notes:*

*11/22/10- 0125 Restless, picking at sheets and pulling at IV tubing. Disoriented to place and time. Dyspnea on exertion noted. Dr. Timmons notified. Stat ABGs ordered.-----  
Mary Minee, RN*

*11/22/10- 0145 Oxygen started at 2 liters per nasal cannula. Incentive Spirometry and deep breathing exercises initiated. Head of bed elevated to 30 degrees.-----Mary Minee, RN*

*Lab reports:*

*pH- 7.30*

*pO<sub>2</sub>- 91mmHg*

*pCO<sub>2</sub>- 50 mmHg*

*HCO<sub>3</sub>- 24 mEq/L*

- 1. Respiratory Alkalosis
- 2. Respiratory Acidosis
- 3. Metabolic Alkalosis
- 4. Metabolic Acidosis

Rationale:

2. Correct: Look at pH? Acid and which other lab says acid....CO<sub>2</sub>. Is CO<sub>2</sub> a respiratory or metabolic chemical? Respiratory. So the condition is Respiratory Acidosis.

1. Incorrect: Not alkalotic condition, the pH is acid.

3. Incorrect: Not metabolic condition, because HCO<sub>3</sub> is normal.

4. Incorrect: Not metabolic condition, because HCO<sub>3</sub> is normal.

10. The nurse is caring for a client, who is 8 hours post- op receiving 40% humidified oxygen. ABG results are:  $pO_2= 91$ ,  $pCO_2= 50$ ,  $pH= 7.30$ ,  $HCO_3= 24$ . Based on this information, which nursing action would be **best**?

- 1. Turn client and encourage coughing and deep breathing.
- 2. Request respiratory therapy to perform postural drainage and percussion.
- 3. Report ABGs to physician and increase oxygen percentage.
- 4. Administer anti-anxiety agent.

Rationale:

1. Correct: If you are 8 hours post-op would you be taking nice deep breaths? No. So what would you be retaining?  $CO_2$  which makes your  $pCO_2$  go up, which makes your pH go down. I'm acidotic aren't I?

2. Incorrect: Requesting postural drainage and percussion form respiratory therapy would not be the best nursing action to address the problem of retaining  $CO_2$ .

3. Incorrect: There's nothing wrong with calling the physician and letting him know about the ABGs but the last part is just wrong. How is oxygen going to help this client? It's not until they get rid of the what?  $CO_2$ . And the only way to rid of the  $CO_2$  is coughing and deep breathing.

4. Incorrect: What are they going to say about you if you select #4? You're a killer. Don't give her a license, because if you give them an anti-anxiety agent what's going to happen to the respiratory rate, decrease, and they are going to retain even more  $CO_2$  and you've just made it worse.

11. After completing a round of chemotherapy, the client's lab results revealed.

Lab Results

*Hgb- 9.0g/dl*

*Hct- 28%*

*WBC- 3,000 mm<sup>3</sup>*

*Platelets- 94,000  
mm<sup>3</sup>*

*Na- 142mEq/L*

*K- 3.8 mEq/L*

Based on this data, what problem should the nurse anticipate? **Select all that apply.**

- ☐ 1. Anemia
- ☐ 2. Leukopenia
- ☐ 3. Thrombocytopenia
- ☐ 4. Hypernatremia
- ☐ 5. Hypokalemia

Rationale:

1., 2. & 3. Correct: Chemotherapy decreases bone marrow production, resulting in reduced red blood cell counts (anemia), reduced white blood cell counts (leukopenia), and reduced platelet counts (thrombocytopenia).

4. Incorrect: The sodium level is normal.

5. Incorrect: The potassium level is also normal.

12. A client weighing 154 pounds is admitted to the burn unit with second and third degree burns covering 40% total body surface area. Normal Saline IV fluid resuscitation is ordered at 4 ml/kg per percentage of total body surface area burned over the first 24 hours. How much fluid does the nurse calculate the client will receive in 24 hours?

Provide your answer in whole numbers

ml

Rationale:

Correct: 11,200 ml in the first 24 hours

$154 \text{ pounds} / 2.2 \text{ kg} = 70 \text{ kg}$

$4 \text{ ml} \times 70 \text{ kg} = 280$

$280 \text{ ml} \times 40 \text{ tbsa} = 11,200 \text{ ml in the first 24 hours}$

13. A client five days post electrical burn states, "I am feeling fine and would like to go home." What is the rationale for this length of stay?

- ☐ 1. Bone damage always occurs resulting in pathologic fractures.
- ☐ 2. Vascular and nerve damage may cause organ failure.
- ☐ 3. Continuous EKG monitoring is always required.
- ☐ 4. Infection is sometimes a delayed response.

Rationale:

2. Correct: The current of electrical burns damages the vascular system and the nerves nearby. This alteration in the vascular system can damage vital organs, and we worry about organ failure.

1. Incorrect: Bones are dense and not really affected by electrical current.

3. Incorrect: Cardiac monitoring is for the first 48 hours, not the reason for a prolonged stay.

4. Incorrect: Infection is not a priority in an electrical burn.



14. A client is hospitalized hundreds of miles from home for a bone marrow transplant. The client is in reverse isolation while undergoing total body irradiation and intense chemotherapy. The client's sibling, who has driven a great distance, comes to visit and has obvious manifestations of an upper respiratory infection. Which nursing action would be **most** appropriate at this time?

- 1. Do not allow the sibling to visit, and do not upset the client by mentioning the sibling's visit.
- 2. Allow the sibling to wave at the client through the window or door, then offer the use of the unit phone so they can talk.
- 3. Allow the sibling to visit donning a sterile gown, mask, and gloves, but prohibit physical contact.
- 4. Allow the sibling to visit after donning a sterile gown, mask, and gloves and have the client wear a mask.

Rationale:

2. Correct: This is the only safe answer for the client.

1. Incorrect: No, allow client to see from distance and talk with client.

3. Incorrect: Sibling does not need to be allowed in the room regardless of protective clothing.

4. Incorrect: Sibling does not need to be allowed in the room regardless of protective clothing.

15. A client is admitted to the Emergency Department with burns to the chest and legs. Which assessment is the **highest** priority?

- 1. Calculating the "Rule of Nines"
- 2. Determining the time of the burn
- 3. Ascertaining if the burn occurred in an enclosed area
- 4. Calculating the Parkland formula

Rationale:

3. Correct: A fire in an enclosed area brings on the concern for carbon monoxide poisoning. In addition with the burns to the chest there is the added potential for airway damage.

1. Incorrect: Important for surface area estimate but not airway.

2. Incorrect: Important for fluid replacement but not #1.

4. Incorrect: Determines the amount of fluid to be replaced, but not airway!

16. The client has returned to your unit after an escharotomy of the forearm. What is the **priority** nursing assessment?

- 1. Infection
- 2. Incision
- 3. Pain
- 4. Tissue perfusion

Rationale:

4. Correct: Yes! They do the escharotomy for circulation problems, check circulation!

1. Incorrect: Not right away!

2. Incorrect: No, that incision is going to be bad and ugly.

3. Incorrect: Well this is the second best answer – the escharotomy for the lack of circulation and pain is one indicator of adequate circulation, so go with the real thing first.

17. A client had surgery for cancer of the colon and a colostomy was performed. Prior to discharge, the client states that he will no longer be able to swim. The nurse's response would be based on which understanding?

- 1. Swimming is not recommended, the client should begin looking for other areas of interest.
- 2. Swimming is not restricted if the client wears a dressing over the stoma at all times.
- 3. The client cannot go into water that is over the stoma area, he can only go into water up to the stoma area.
- 4. There are no restrictions on the activity of a client with a colostomy; all previous activities may be resumed.

Rationale:

4. Correct: With the colostomy bag providing an airtight seal they can take a shower, bath, and go swimming.

1. Incorrect: Swimming is allowed with the airtight seal that the colostomy bag provides.

2. Incorrect: Client will wear colostomy bag with airtight seal not a dressing over the stoma.

3. Incorrect: No, the client can swim with the airtight seal colostomy bag.

18. The nurse is evaluating whether a client understands the procedure for collecting a 24 hour urine sample. The nurse recognizes that teaching was successful when the client makes which statements? **Select all that apply.**

- ☐ 1. "I should start the 24 hour urine collection at the time of my first saved urine specimen."
- ☐ 2. "If I forget to collect any urine, I will need to start over."
- ☐ 3. "It is important to ensure that no feces or toilet tissue mixes with the urine."
- ☐ 4. "When the 24 hours is up, I need to void and collect that specimen."
- ☐ 5. "The urine specimen should be stored in my refrigerator during collection."

Rationale:

2., 3. & 4. Correct: Missed specimens make the collection inaccurate. The test should be started over. Contamination can alter the test. The last specimen should be obtained at the end of the 24 hour period.

1. Incorrect: The time begins with the first voiding, however that voiding is discarded.

5. Incorrect: Urine should be placed on ice or left at room temperature if an additive has been used. You do not want the client to store the specimen in their refrigerator.

19. After gathering supplies, explaining the procedure, putting the client in a high fowlers position, and washing hands, the nurse begins to clean a client's tracheostomy. Place the steps in the proper order. **All options must be used.**

1. Soak inner cannula in peroxide.
2. Reinsert cannula with non-dominant hand and lock into place.
3. Prepare sterile supplies, hydrogen peroxide and normal saline.
4. Don sterile gloves.
5. Rinse and dry inner cannula with pipe cleaner.
6. Put on clean gloves to remove soiled dressing.
7. Secure tracheostomy with clean twill tape.
8. Cleanse the wound and plate of the tracheostomy tube with sterile cotton tipped applicator.
9. Remove old twill tape.

Rationale:

6., 3., 4., 8., 1., 5., 2., 7. & 9. Correct: This is the proper procedure for trach care.

20. The client with Addison's disease demonstrates an understanding of steroid therapy by which statement?

- 1. "I'll take my medicine at night to help me sleep."
- 2. "My medication dosage will be adjusted frequently."
- 3. "I will limit my sodium intake to 200 mg per day."
- 4. "I will weigh myself weekly to monitor medication effectiveness."

Rationale:

2. Correct: Steroid therapy is adjusted according to the client's weight and signs of fluid volume status.

1. Incorrect: Steroids can cause insomnia.

3. Incorrect: This client needs a high sodium diet as they are losing sodium and retaining potassium.

4. Incorrect: Weights are done daily to adjust medication dosage not weekly.

21. The nurse is admitting a client with new onset Diabetes mellitus. Which findings does the nurse expect while completing the medical history and physical examination of this client?

**Select all that apply.**

- ☐ 1. History of recurrent vaginal yeast infections
- ☐ 2. Complaints of intolerance to the cold
- ☐ 3. Slow, slurred speech noted
- ☐ 4. Prescription change for glasses needed twice in past year
- ☐ 5. Complaints of wanting to eat all the time
- ☐ 6. Amenorrhea

Rationale:

1., 4. & 5. Correct: Polyuria, polyphagia, and polydipsia are classic symptoms of diabetes. With type II diabetes the manifestations are often nonspecific. Common manifestations include fatigue, recurrent infections, recurrent vaginal yeast or monilial infections, prolonged wound healing, and visual changes. Unfortunately, the clinical manifestations appear so gradually that an individual may blame the symptoms on another cause such as lack of sleep or increasing age, and before the person knows it, he or she may have complications.

2. Incorrect: This is a manifestation of hypothyroidism.

3. Incorrect: This is a manifestation of hypothyroidism.

6. Incorrect: This is a manifestation of hypothyroidism.

22. A nurse caring for a cancer client is teaching the client about precautions concerning the client's risk for bleeding problems. The nurse identifies that teaching has been successful regarding bleeding precautions when the client makes which statement? **Select all that apply.**

- ☐ 1. "I cannot shave while I am at risk for bleeding."
- ☐ 2. "It is important to gargle with a commercial mouthwash three times a day."
- ☐ 3. "Stool softeners will help prevent rectal bleeding."
- ☐ 4. "Prior to sexual intercourse, I will use a water-based lubricant."
- ☐ 5. "I will use a soft toothbrush."

Rationale:

3., 4. & 5. Correct: Stool softeners prevent constipation and straining that may injure rectal tissue. Water-based lubricant will prevent friction and tissue trauma. Soft toothbrush will prevent trauma to gum tissue.

1. Incorrect: The client can shave with an electric razor. An electric razor will prevent trauma.

2. Incorrect: Commercial mouthwash should be avoided as they contain high alcohol content that will dry oral tissues and lead to bleeding.

23. The nurse is caring for a client that is paranoid in the locked psychiatric unit. It is time for the client's individual session, but the client is very agitated with outburst of shouting. What would be the nurse's **best** action at this time?

- 1. Have the client sit with you and say a prayer.
- 2. Explain that shouting is not allowed and send them to group session.
- 3. Redirect the client to another activity.
- 4. Call for assistance and put the client in seclusion.

Rationale:

3. Correct: Yes! Get them active. Redirect their activity. This is too much for them right now.

1. Incorrect: They are agitated, shouting...Now you think it is reasonable to get them to sit and pray? Nope!

2. Incorrect: Setting limits is good, but here the client is disruptive.

4. Incorrect: Oh boy – it's going to be a fight! NO! That's not nice.

24. Which dietary consideration is the **most** important for the nurse to teach to a client with hypothyroidism?

- 1. Increase carbohydrate intake.
- 2. Increase fluid intake.
- 3. Avoid shellfish.
- 4. Increase fiber.

Rationale:

4. Correct: YES! Low thyroid clients have constipation, so increased fiber.

1. Incorrect: No they need less calories, not more. Their metabolism is slowed.

2. Incorrect: What does increasing fluid have to do with it? Nothing

3. Incorrect: What does avoiding shellfish have to do with it? Nothing...that's if they are allergic to iodine.

25. Following a thyroidectomy a client is complaining of shortness of breath and neck pressure. What should the nurse do?

- 1. Stay with the client, remove the dressing, and elevate the head of bed.
- 2. Call a code, open the trach set and position the client flat supine.
- 3. Have the client say "EEE" to check for laryngeal integrity and assess Chvostek's sign.
- 4. Call the doctor and assess vital signs.

Rationale:

1. Correct: Yes! Sounds like respiratory distress, Looks like respiratory distress, get that dressing off the neck and see if they can breathe any better.

2. Incorrect: Not yet! Do something first to see if it gets better.

3. Incorrect: Well just look and check and look and check – do something.

4. Incorrect: Don't leave the client.

26. A client is admitted for evaluation of cardiac arrhythmias. What would be the **most** important information to obtain when assessing this client?

- 1. Ability to perform isometric exercises as ordered.
- 2. Changes in level of consciousness or behavior.
- 3. Recent blood sugar changes.
- 4. Compliance with dietary fat restrictions.

Rationale:

2. Correct: The only answer that deals with cardiac output is #2. When the cardiac output drops, then the LOC will decrease.

1. Incorrect: What do isometrics have to do with cardiac output?

3. Incorrect: What does blood sugar have to do with cardiac output?

4. Incorrect: Arrhythmias have nothing to do with fat.

27. The nurse is caring for a client with deep vein thrombosis of the left leg. Which nursing goal would be **most** appropriate for this client?

- 1. To decrease inflammatory response in the affected extremity.
- 2. To increase peripheral circulation.
- 3. To prepare client and family for anticipated vascular surgery.
- 4. To prevent hypoxia associated with the development of pulmonary emboli.

Rationale:

1. Correct: When blood sets in one area it inflames the area, and a clot can form.

2. Incorrect: You do not need oxygen when you have a venous problem. The only time you need oxygen is when you have an arterial problem.

3. Incorrect: Getting ahead of yourself.

4. Incorrect: Getting ahead of yourself.

28. A six-year-old client has been receiving chemotherapy for two weeks. The laboratory results show a platelet count of 20,000. What is the **priority** nursing action?

- 1. Encourage quiet play.
- 2. Avoid persons with infections.
- 3. Administer p.r.n. oxygen.
- 4. Provide foods high in iron.

Rationale:

1. Correct: With a low platelet count you are at risk for bleeding, and quiet play will decrease the risk of injury.
2. Incorrect: The priority is risk for bleeding with the low platelet count, not infection.
3. Incorrect: There is no indication that client has low RBC's or anemia.
4. Incorrect: There is no indication that client has low iron.

29. A nurse is caring for a client diagnosed with heart failure (HF). The client currently takes furosemide (Lasix) 40mg every morning. Potassium 20mEq daily, digoxin (Lanoxin) 0.25mg every day. Which client comment should the nurse assess **first** in caring for this client?

- 1. "My fingers and feet are swollen."
- 2. "My weight is up 1 pound."
- 3. "There is blood in my urine."
- 4. "I am having trouble with my vision."

Rationale:

4. Correct: Did you see the sign of Dig toxicity? Good Job!
1. Incorrect: History of heart failure, edema is common- may need bed rest or additional diuretic therapy- not usually life threatening.
2. Incorrect: No, weight should not vary more than 3-5 pounds.
3. Incorrect: Needs investigation, but digoxin toxicity comes first- more lethal.



30. After a left heart catheterization, a client reports severe foot pain on the side of the femoral stick. The nurse notes pulselessness, pallor, and cold extremity. What should be the nurse's next action?

- 1. Administer an anticoagulant .
- 2. Warm the room and re-assess.
- 3. Increase IV fluids.
- 4. Notify the physician stat.

Rationale:

4. Correct: This is an emergency, and the doctor is the only one that can save this foot from ischemia – don't delay.

1. Incorrect: Anticoagulants stabilize clots, not lyse – thrombolytics lyse clots..too aggressive – just report and get some help coming.

2. Incorrect: These symptoms are too severe for warming the room.

3. Incorrect: Well, in theory, increasing blood volume increases blood flow – but this client has an arterial obstruction.

31. A client is admitted to the medical unit with a diagnosis of Addison's disease. What nursing interventions should the nurse implement for this client? **Select all that apply.**

- ☐ 1. Administer potassium supplements as ordered.
- ☐ 2. Assist the client to select food high in sodium.
- ☐ 3. Administer Fludrocortisone (Florinef) as ordered.
- ☐ 4. Monitor intake and output.
- ☐ 5. Record daily weight.

Rationale:

2., 3., 4. & 5. Correct: The client with Addison's disease needs sodium due to low levels of aldosterone. Florinef is a mineralocorticoid that the client will need to take lifelong. I&O and daily weights are needed to monitor fluid status.

1. Incorrect: Clients with Addison's disease lose sodium and retain potassium, so this client does not need potassium.

32. In planning a menu for a client suffering from an acute manic episode, which meal would the nurse determine to be **most** appropriate?

- 1. Spaghetti and meat balls, salad, banana
- 2. Beef and vegetable stew, bread, vanilla pudding
- 3. Fried chicken leg, ear of corn, apple
- 4. Fish fillets, stewed tomatoes, cake

Rationale:

3. Correct: Something they can hold in their hand and it is high calorie.

1. Incorrect: Spaghetti is too frustrating for anyone....Never give a manic client something frustrating to eat.

2. Incorrect: It's hard to walk around and eat beef stew.

4. Incorrect: It's hard to walk around and eat stewed tomatoes.

33. The manic client has just interrupted the counselor's group session for the 4th time and states "I already know this information dealing with others when you are down." What should the nurse do at this time?

- 1. Engage the client to walk with you to make another pot of coffee.
- 2. Ask the client to reflect on the client's behavior to determine if it is appropriate.
- 3. Ask the group to tell the client how they feel when she interrupts.
- 4. Instruct the client to perform jumping jacks and counting aloud to get rid of some energy.

Rationale:

1. Correct: Yes! Get them away and doing something purposeful.

2. Incorrect: That is embarrassing and humiliating to the client.

3. Incorrect: Sometimes this will be helpful during times of therapy – but the client is manic at this time, will she even believe them?

4. Incorrect: No, this is getting her active, but can the group continue with this attention seeking jumping, counting person? No. Get her away from the activity.

34. After examining the eyes of the following client, the nurse would expect which correlating lab work?



- 1. Elevated cortisol level
- 2. Elevated thyroxine levels
- 3. Decreased parathormone levels
- 4. Increased calcitonin level

Rationale:

2. Correct: Exophthalmos is a classic finding in Graves' disease. It is a protrusion of the eyeballs from the orbits due to impaired venous drainage from the orbit, which causes increased fat deposits and edema in the retro-orbital tissues. To diagnose hyperthyroid or Grave's Disease you do a thyroxine level which when elevated indicates a hyperthyroid state.

1. Incorrect: This would indicate hyperfunctioning of the adrenal gland as in Cushing's syndrome.

3. Incorrect: This lab would indicate hypoparathyroidism.

4. Incorrect: Again, this level would tell you about the parathyroid.

35. A client with schizophrenic disorder begins to talk about fantasy material. What would be the **most** appropriate nursing action?

- 1. Encourage the client to focus on reality-based issues.
- 2. Allow the client to continue to talk so as not to interrupt the delusion.
- 3. Ask the client to explain the meaning behind what he is saying.
- 4. Persuade the client that his thoughts are not true.

Rationale:

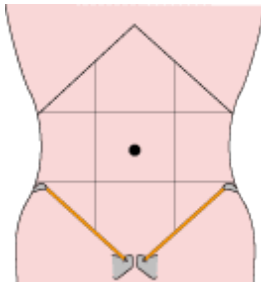
1. Correct: Get them out of the delusion to get into the real world.

2. Incorrect: Never allow clients to continue on in a delusion....this is reinforcing it.

3. Incorrect: Reinforcing the delusion.

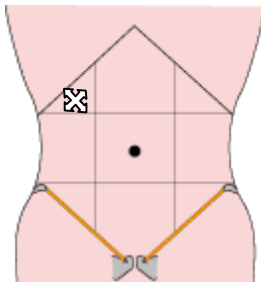
4. Incorrect: Waste of time....produces anxiety.

36. A client has been admitted to the medical unit with hepatitis B. Identify what quadrant the nurse would assess for hepatomegaly. Place an “x” in the correct location.



Rationale:

Correct: The liver is located under the right lower rib cage. The liver may be palpable in the right upper quadrant.



37. Which client is at **highest** risk for suicide?

- ☐ 1. Seventy-six year old widower with chronic renal failure
- ☐ 2. Nineteen year old taking antidepressants
- ☐ 3. Twenty-eight year old post-partum crying weekly
- ☐ 4. Fifty year old with obsessive-compulsive disorder (OCD)

Rationale:

1. Correct: Yes- elderly with chronic disease, especially men, are very high risk.
2. Incorrect: There is an increased incidence and risk in this population-but look for the highest risk.
3. Incorrect: Many post-partum clients cry weekly, this is not the red flag client.
4. Incorrect: Chronic disease, but the widower wins out as the higher risk.

38. A client with a T4 lesion is being cared for on the neuro rehabilitation unit. The client suddenly reports a severe, pounding headache. Profuse diaphoresis is noted on the forehead. The blood pressure is 180/112 and the heart rate is 56. What interventions should the nurse initiate?

**Select all that apply.**

- ☐ 1. Place the client supine with legs elevated.
- ☐ 2. Assess bladder and bowel for distention.
- ☐ 3. Examine skin for pressure areas.
- ☐ 4. Eliminate drafts.
- ☐ 5. Remove triggering stimulus.
- ☐ 6. Administer hydralazine (Apresoline) if BP does not return to normal.

Rationale:

2., 3., 4., 5. & 6. Correct: All appropriate interventions for autonomic dysreflexia. This condition occurs in clients with a T6 or lower injury. The autonomic nervous system sends out a massive sympathetic response (epi and norepi) to stimuli. The stimuli is one that would not bother a healthy person but very dangerous to a spinal injury client, i.e. bladder or bowel distention, pressure areas in the bed, drafts, and other simple triggers.

1. Incorrect: The client should be placed immediately in a sitting position to lower blood pressure.

39. A client who is fourth day post-op cholecystectomy reports severe abdominal pain. During the initial assessment he states, "I have had two almost black stools today." Which nursing action is **most** important?

- 1. Start an IV with D5W at 125 ml/hr.
- 2. Insert a nasogastric tube.
- 3. Notify the physician.
- 4. Obtain a stool specimen.

Rationale:

3. Correct: What's going on inside? They are hemorrhaging. Assume the worst. The physician is the only one who can stop the bleeding.

1. Incorrect: There's nothing wrong with starting an IV, but isn't the client bleeding while you do this?

2. Incorrect: How does that help the bleeding stop? It doesn't.

4. Incorrect: You are going to wait on a stool specimen and Hemocult. Don't delay care, notify the physician first.

40. A construction worker comes into the occupational health nurse's clinic reporting chest heaviness. What other signs and symptoms does the nurse expect to find if myocardial infarction is suspected? **Select all that apply.**

- ☐ 1. Headache
- ☐ 2. Indigestion
- ☐ 3. Lightheadedness
- ☐ 4. Dyspnea
- ☐ 5. Irregular pulse

Rationale:

2., 3., 4. & 5. Correct: Chest pains or discomfort not relieved by rest or nitroglycerin. Palpitation. If heart failure occurs, BP maybe increased because of sympathetic stimulation or decreased because of decreased contractility, impending cardiogenic shock, medications. Irregular pulse due to atrial fibrillation, shortness of breath, tachypnea, crackles due to pulmonary congestion, n/v, decreased UOP due to cardiogenic shock, as well as cool clammy skin. Anxiety, restlessness, lightheadedness.

1. Incorrect: Headaches do not commonly occur with MI.

41. The nurse is caring for a client complaining of intense headaches with increasing pain for the past month. A Magnetic Resonance Imaging (MRI) is ordered. In reviewing the client's information, which piece of information is of concern?

- ☐ 1. Allergic to shellfish
- ☐ 2. Cardiac pacemaker
- ☐ 3. Diabetic
- ☐ 4. No IV access

Rationale:

2. Correct: Yes! IF a client with a cardiac pacemaker has an MRI the pacemaker is turned off and the client could die.

1. Incorrect: No – there is no dye involved with MRI

3. Incorrect: No- The client does not need to be NPO or have any modifications of their medications

4. Incorrect: None needed

42. A newly diagnosed diabetic client is demonstrating to the nurse how to draw up regular insulin 15 units and NPH insulin 10 units into the same syringe. The nurse knows that the client successfully demonstrates this procedure if done in what order? Place in the correct order. **All options must be used.**

1. Inject 15 units of air into regular insulin bottle.
2. Inject 10 units of air into NPH insulin bottle.
3. Prepare skin site and inject insulin.
4. Roll insulin bottles between hands.
5. Draw up 10 units of NPH insulin into the insulin syringe.
6. Draw up 15 units of regular insulin into insulin syringe.
7. Wipe the top of insulin bottles.

Rationale:

4., 7., 2., 1., 6., 5. & 3. Correct: This is the correct procedure.

43. What must the nurse do while caring for a client with an eating disorder?

- 1. Encourage client to cook for others.
- 2. Weight the client daily and keep a journal.
- 3. Restrict access to mirrors.
- 4. Monitor food intake and behavior for one hour after meals.

Rationale:

4. Correct: Yes! This is the primary problem and the most life threatening.

1. Incorrect: No – remember the focus is on control and attention to food – they need to eat.

2. Incorrect: No – we don't let them know their weight, if they gain one ounce, they will try anything to lose it!

3. Incorrect: They still have to brush their hair and put on make-up – it's the eating we just focus on to keep them alive.

44. Which condition would warrant the nurse discontinuing the intravenous infusion of oxytocin (Pitocin)?

- 1. Fetal heart rate baseline of 140-160 bpm
- 2. Contractions every 1-1/2 minutes lasting 70-80 seconds
- 3. Maternal temperature of 101.2 degrees
- 4. Early decelerations in the fetal heart rate

Rationale:

2. Correct: These contractions are too long and too often.

1. Incorrect: That heart rate is fine.

3. Incorrect: Temperature has nothing to do with Pitocin (uterine contractions).

4. Incorrect: Early decels are no big deal.

45. In preparing care for a client with Parkinson's disease, which nursing diagnoses should the nurse include? **Select all that apply.**

- ☐ 1. Impaired physical mobility related to muscle rigidity
- ☐ 2. Imbalanced nutrition, greater than body requirements related to limited exercise
- ☐ 3. Self-care deficits related to motor disturbance
- ☐ 4. Impaired verbal communication related to inability to move facial muscles
- ☐ 5. Unilateral neglect related to muscle paralysis.

Rationale:

1., 3. & 4. Correct: These are appropriate nursing diagnoses for a client with Parkinson's disease.

2. Incorrect: The client is more likely to have imbalanced nutrition, less than body requirements, related to tremor, slowness in eating, difficulty in chewing and swallowing.



46. The client is transferred to the Neuro Unit after developing right sided paralysis and aphasia. Which nursing action should be included in the nursing care plan in order to promote communication with the client?

- 1. Encourage client to shake head in response to questions.
- 2. Speak in a loud voice during interactions.
- 3. Speak using phrases and short sentences.
- 4. Encourage the use of radio to stimulate the client.

Rationale:

3. Correct: Client is having trouble communicating. Get simple. Promote communication.

1. Incorrect: Never pick an answer that doesn't allow the client to speak. They haven't told us what kind of aphasia. They could have expressive aphasia.

2. Incorrect: Don't yell at the client.

4. Incorrect: Use of radio will not promote communication with the client. Radio should be turned off when communicating with client to decrease distraction.

47. The client delivered a 9-pound 12-ounce baby 1 hour ago. You note during her 15-minute assessment that she saturated 2 pads and that she is lying in a small puddle of blood. Which nursing action should take **priority**?

- 1. Call for assistance.
- 2. Massage the fundus if boggy.
- 3. Assess vital signs.
- 4. Assess the perineum for tears.

Rationale:

2. Correct: This is the only answer that will STOP BLEEDING!!!!

1. Incorrect: Call for assistance...doesn't stop the bleeding...since it says priority you have to say...if I could only do ONE thing...if you choose this answer you get assistance in the room, but you have not STOPPED THE BLEEDING.

3. Incorrect: This is good, but how will it stop the bleeding.

4. Incorrect: The perineum is not what's hemorrhaging.

48. The nurse is caring for a client with pneumonia. Which nursing observation would indicate a therapeutic response to the treatment for the infection?

- 1. Oral temperature of 101 degrees F., increased chest pain with non-productive cough
- 2. Productive cough with thick green sputum, states feels tired
- 3. Respirations 20, with no complaints of dyspnea, moderate amount of thick white sputum
- 4. White cell count of 10,000 mm<sup>3</sup>, urine output at 40 cc/hr, no sputum

Rationale:

3. Correct: You will have sputum a while after pneumonia, but if it is white there is no infection.

1. Incorrect: Temperature is still too high and they are having chest pains.

2. Incorrect: Green sputum means infection is still there.

4. Incorrect: If pneumonia is the problem, you do not check kidneys. With pneumonia you will have sputum for a while.

49. Which nursing action would be included in planning care for a client with signs of increased intracranial pressure?

- 1. Encourage coughing and deep-breathing to prevent pneumonia.
- 2. Suction airway every 2 hours to remove secretions.
- 3. Position the client in the prone position to promote venous return.
- 4. Determine cough reflex and ability to swallow prior to administering PO fluids.

Rationale:

4. Correct: If I have increased ICP my reflexes could be suppressed.

1. Incorrect: Makes ICP go up.

2. Incorrect: Makes ICP go up.

3. Incorrect: Makes ICP go up.

50. Which postpartum client requires the last private room in the Women's Health Center?

- 1. A client who had an abruption during her delivery 22 hours ago
- 2. A client who had a boggy fundus five hours post-delivery
- 3. A client who was pre-eclamptic prior to delivery 30 hours ago, with vital signs now normal.
- 4. A client who delivered by c-section whose WBC count is 24,000

Rationale:

3. Correct: This pre-eclamptic client delivered 30 hours ago....They are trying to make you think that everything is OKAY because they say AFTER delivery... they must have a private room because ANY STIMULI can precipitate a seizure.

1. Incorrect: People who are at risk for bleeding and shock do not require private rooms.

2. Incorrect: Boggy fundus....doesn't have anything to do with a private room.

4. Incorrect: This is the one most people jump on.... They thought you would jump on this...all ladies who have had babies have elevated white counts post-delivery.

51. The nurse will be admitting a client from the operating room following a left pneumonectomy for adenocarcinoma. Which type of chest drainage system should the nurse anticipate the client will have?

- 1. Bilateral chest tubes.
- 2. One chest tube on the operative side.
- 3. Two chest tubes on the operative side.
- 4. No chest drainage will be necessary.

Rationale:

4. Correct: Pneumonectomy means the ENTIRE lung has been removed.

1. Incorrect: No, the entire lung has been removed.

2. Incorrect: No, the entire lung has been removed.

3. Incorrect: Again, the entire lung has been removed.

52. After administration of epidural anesthesia, the laboring client's blood pressure drops to 92/42. What would be the **priority** nursing intervention?

- 1. Elevate the head of the bed.
- 2. Begin oxygen by face mask at 40%.
- 3. Change her position to side-lying.
- 4. Begin dopamine as ordered.

Rationale:

3. Correct: When you turn them on their side this relieves pressure on the vena cava and the BP will go UP.

1. Incorrect: This will drop the pressure more.

2. Incorrect: O<sub>2</sub> doesn't bring up the BP.

4. Incorrect: Stay away from drugs as long as you can.....Besides this says a NURSING ACTION.

53. The client is admitted to the hospital following a motor vehicle accident and has sustained a closed chest wound. Which assessment finding is consistent with flail chest?

- 1. Biot's breathing
- 2. Sucking sounds with respirations
- 3. Paradoxical chest wall movement
- 4. Hypotension and bradycardia

Rationale:

3. Correct: Hallmark of flail chest!

1. Incorrect: No, but it's associated with neurological problems.

2. Incorrect: Open chest wounds suck not closed chest wounds.

4. Incorrect: Well, the hypoxia and trauma will lead to hypotension and tachycardia, not bradycardia.

54. The nurse is caring for a client 28 weeks pregnant that reports swollen hands and feet. Which symptom below would cause the **most** concern?

- 1. Nasal congestion
- 2. Hiccoughs
- 3. Capillary blood glucose of 150
- 4. Muscle spasms

Rationale:

4. The muscle spasms – watch for seizure.

1. No, they always have a stuffy nose.

2. Hiccoughs would be second best answer indicating nerve/muscle irritation.

3. Is this right after dairy queen?

55. The nurse is writing a care plan for a client admitted following chest tube placement for a spontaneous pneumothorax. Which intervention would be appropriate for the nurse to include?

- 1. Keep the water seal chamber at the level of the right atrium.
- 2. Tape all connections between the chest tube and drainage system.
- 3. Notify the physician if there is continuous bubbling in the suction control chamber.
- 4. Empty the collection chamber and record the amount of drainage every shift.

Rationale:

2. Correct: Tape all connections.

1. Incorrect: Must be kept below the chest.

3. Incorrect: If it's hooked to suction it's suppose to bubble.

4. Incorrect: Empty every shift? Don't empty them, you change them out when they get full.

56. A child with a radial fracture reports itching to the casted area. What is the appropriate nursing action to relieve itching?

- 1. Allow the child to use a Q-tip to scratch the area.
- 2. Visualize the toes and area above the cast to identify areas of irritation.
- 3. Apply an ice pack for 10-15 minutes.
- 4. Explain to the child that itching is an indication the fracture is healing.

Rationale:

3. Correct: This will change the sensation.....Normally the answer is use a cool blow dryer, but they wanted to see if you would be flexible with what you know. Use an ice pack that will not get the cast wet.

1. Incorrect: A Q-tip is soft, trying to make you feel like this is okay to put into a cast.

2. Incorrect: How does visualizing toes decrease itching....it doesn't.

4. Incorrect: How does explaining the Pathophysiology help decrease itching? It doesn't.

57. Following a hip replacement surgery, an elderly client is ordered to begin ambulation with a walker. In planning nursing care, which statement by the nurse will **best** help this client?

- 1. Sit in a low chair for ease in getting up in a walker
- 2. Make sure rubber caps are present on all 4 legs of the walker
- 3. Begin weight-bearing on the affected hip immediately.
- 4. Practice tying your shoes before using the walker

Rationale:

2. Correct: Rubber caps on all 4 legs of walker will prevent falls.

1. Incorrect: If the client sits in a low chair, their hip may dislocate. You prevent hip flexion greater than 90 degrees and leg adduction. Both can cause dislocation.

3. Incorrect: We do not begin weight bearing immediately but as soon as the physician says.

4. Incorrect: If you bend over to tie your shoes, what is your hip going to do- dislocate. You prevent hip flexion greater than 90 degrees and leg adduction. Both can cause dislocation.

58. The nurse is caring for a client in the 8th week of pregnancy. The client is spotting, has a rigid abdomen and is on bed rest. What is the **most** important assessment at this time?

- 1. Protein in the urine
- 2. Fetal heart tones
- 3. Cervical dilation
- 4. Hemoglobin and hematocrit levels

Rationale:

4. Correct: The client may be bleeding! And that is an emergency!

1. Incorrect: We are not worried about pre-eclampsia right now with this situation .

2. Incorrect: We can't hear them yet.

3. Incorrect: No vaginal exams! We don't want any stimulation to the cervix now.

59. A client is preparing to be discharged after a total hip replacement. Which statements, if made by the client, would indicate to the nurse that teaching has been successful regarding prevention of hip prosthesis dislocation? **Select all that apply.**

- ☐ 1. "I should not cross my affected leg over my other leg."
- ☐ 2. "I should not bend at the waist more than 90 degrees."
- ☐ 3. "While lying in bed, I should not turn my affected leg inward."
- ☐ 4. "It is necessary to keep my knees together at all times."
- ☐ 5. "When I sleep, I should keep a pillow between my legs."

Rationale:

1., 2., 3. & 5. Correct: These are appropriate actions to prevent hip prosthesis dislocation. Until the hip prosthesis stabilizes it is necessary to follow these instructions for proper positioning to avoid dislocation.

4. Incorrect: The knees should be kept apart at all times, to prevent dislocation.

60. The client presents to the emergency department with no known injury and back pain so severe they cannot walk. The client describes the pain as coming in waves. What should the nurse do **first**?

- 1. Medicate for pain
- 2. Obtain urine specimen
- 3. Check the patellar reflex
- 4. Provide gentle stretching maneuvers

Rationale:

2. Correct: Yes, high suspicion for renal calculi

1. Incorrect: No, we must investigate the pain before we cover it up – pain is a symptom.

3. Incorrect: Not helpful in this situation

4. Incorrect: Not helpful- maybe harmful

61. The nursing supervisor is observing a nurse caring for a client with a chest drainage system receiving 20 cm of suction. The nursing supervisor recognizes proper procedure by the nurse when the nurse performs which action? **Select all that apply.**

- ☐ 1. Maintain chest drainage system below the client's chest during transport.
- ☐ 2. Apply tape to the connection tubes.
- ☐ 3. Add sterile saline to suction control chamber to achieve 20 cm.
- ☐ 4. Clamp the tubing to assess respiratory effort.
- ☐ 5. Ensure that tubing is not kinked or looped.

Rationale:

1., 2., 3. & 5. Correct: Never raise the drainage system above the level of the client's chest. All connection sites should be tightly secured. If the water level drops below the prescribed suction, more saline must be added. Tubing must not be kinked or looped.

4. Incorrect: The chest tubing should not be clamped as this could lead to tension pneumothorax.



62. What is the diet of choice for a client on hemodialysis?

- 1. Extra protein, low sodium, fluid restriction
- 2. Fluid restriction, low sodium, low protein
- 3. Low sodium, low potassium, low carbohydrates
- 4. Extra carbohydrates, low fat, low sodium

Rationale:

2. Correct: Yes, we need low protein diet to restrict the waste build up. The client will get dialyzed every other day so restrict the fluid, and restrict the sodium to stop the thirst and fluid excess.

1. Incorrect: Not extra protein.

3. Incorrect: Low carbohydrates

4. Incorrect: Doesn't restrict either protein or fluid

63. In order to maintain asepsis, what should the client on home peritoneal dialysis be taught?

- 1. Drink only distilled water
- 2. Cap Tenckhoff catheter when not in use
- 3. Boil the dialysate one hour.
- 4. Clean the arteriovenous fistula with hydrogen peroxide daily

Rationale:

2. Correct: Capping the Tenckhoff catheter prevents dialysate leakage and bacterial invasion.

1. Incorrect: What does drinking distilled water have to do with it? Nothing

3. Incorrect: They thought they would throw this one in there, maybe they could get you into boiling that dialysate, and burn out the peritoneum so we don't have to worry about this anymore we can go straight to hemo now.

4. Incorrect: Do you have an arteriovenous fistula? Not with peritoneal dialysis. That goes with hemodialysis.

64. A client returns to the nursing unit post-thoracotomy with two chest tubes in place connected to a drainage device. The client's spouse asks the nurse about the reason for having two chest tubes. The nurse's response is based on the knowledge that the lower chest tube is placed to:

- 1. Remove air from the pleural space.
- 2. Create access for irrigating the chest cavity.
- 3. Evacuate secretions from the bronchioles and alveoli.
- 4. Drain blood and fluid from the pleural space.

Rationale:

4. Correct: Fluid will drain down and the lower chest tube is for drainage of blood and fluid from pleural space.

1. Incorrect: The top chest tube will remove air from pleural space.

2. Incorrect: No, a nurse will not irrigate the chest cavity.

3. Incorrect: No, chest tube is in pleural space.

65. The nurse is caring for a female that is preparing to undergo a total hysterectomy for advanced cervical cancer. The client is crying and says that she wants to have more children and is unsure if she should have the procedure. What should the nurse do?

- 1. Allow the client to discuss her fears and encourage her to talk with her physician.
- 2. Tell her the good things that she will be able to do without more children.
- 3. Explain to the client that her ovaries can be frozen for egg harvesting at a later time.
- 4. Advise the client to put off having the surgery until she is sure.

Rationale:

1. Correct: This may be anticipatory grieving and being scared. Let the person talk and encourage them to talk again to the physician. They need reassurance that they are making the right decision.

2. Incorrect: This is not her fear and not helpful in this situation.

3. Incorrect: Not an appropriate answer and we don't freeze ovaries.

4. Incorrect: The cancer is already advanced stages, will the waiting help her survive?

66. You are assisting a burn client at the scene of the fire. Which intervention will prevent infection?

- 1. Do nothing until the client arrives in Emergency Department.
- 2. Cleanse the burn with betadine.
- 3. Apply antibiotic ointment and wrap with a kerlix.
- 4. Remove non adherent clothing and wrap in a clean sheet or clothing.

Rationale:

4. Correct: Yes, this can be done at the scene.

1. Incorrect: No, doing nothing is not the right action.

2. Incorrect: At the scene betadine is not available.

3. Incorrect: At the scene antibiotic ointment and kerlix is not available.